

## Paducah Dermatology, PLLC Patient History Form

**Date:** \_\_\_\_\_ **Referring Provider:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ (circle one) Male Female  
**Females:** Pregnant Yes  No  (Weeks \_\_\_\_\_) Trying to become pregnant? Yes  No

**Drug Allergies:**

List Name of Drug(s) below:	What type of allergic reaction?

**Current Medications (both Rx and Herbal): Name of Medication & Dosage**


**Preferred Pharmacy and Location:**

### History of Present Illness

**Problem 1:** \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Location: _____</li> <li>• Duration: _____</li> <li>• Treatment <input type="checkbox"/> None: _____<br/> <input type="checkbox"/> OTC: _____<br/> <input type="checkbox"/> Prescription: _____</li> </ul> | <ul style="list-style-type: none"> <li>• Symptoms &amp; Severity</li> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Itching-mild/mod/severe</li> <li><input type="checkbox"/> Pain-mild/mod/severe</li> <li><input type="checkbox"/> Bleeding-mild/mod/severe</li> <li><input type="checkbox"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li>• Growths/Moles:(not for Rashes)</li> <li><input type="checkbox"/> Changing Colors</li> <li><input type="checkbox"/> Enlarging</li> <li><input type="checkbox"/> Changing Shape</li> <li><input type="checkbox"/> No Change</li> </ul> |
|---|--|---|

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**Problem 2:** \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Location: _____</li> <li>• Duration: _____</li> <li>• Treatment <input type="checkbox"/> None: _____<br/> <input type="checkbox"/> OTC: _____<br/> <input type="checkbox"/> Prescription: _____</li> </ul> | <ul style="list-style-type: none"> <li>• Symptoms &amp; Severity</li> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Itching-mild/mod/severe</li> <li><input type="checkbox"/> Pain-mild/mod/severe</li> <li><input type="checkbox"/> Bleeding-mild/mod/severe</li> <li><input type="checkbox"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li>• Growths/Moles:(not for Rashes)</li> <li><input type="checkbox"/> Changing Colors</li> <li><input type="checkbox"/> Enlarging</li> <li><input type="checkbox"/> Changing Shape</li> <li><input type="checkbox"/> No Change</li> </ul> |
|---|--|---|

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**Problem 3:** \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Location: _____</li> <li>• Duration: _____</li> <li>• Treatment <input type="checkbox"/> None: _____<br/> <input type="checkbox"/> OTC: _____<br/> <input type="checkbox"/> Prescription: _____</li> </ul> | <ul style="list-style-type: none"> <li>• Symptoms &amp; Severity</li> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Itching-mild/mod/severe</li> <li><input type="checkbox"/> Pain-mild/mod/severe</li> <li><input type="checkbox"/> Bleeding-mild/mod/severe</li> <li><input type="checkbox"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li>• Growths/Moles:(not for Rashes)</li> <li><input type="checkbox"/> Changing Colors</li> <li><input type="checkbox"/> Enlarging</li> <li><input type="checkbox"/> Changing Shape</li> <li><input type="checkbox"/> No Change</li> </ul> |
|---|--|---|

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**Family History (parents, siblings, grandparents) (Check appropriate box)**

Asthma    (COPD) Lung Disease    Eczema    Hay Fever(Seasonal allergies)    Psoriasis  
 Stroke    Cancer: Type: \_\_\_\_\_  
 Skin Cancer:    Basal Cell CA    Squamous Cell CA    Melanoma  
 None    Other \_\_\_\_\_

**Social History (Check appropriate box)**

Occupation (Job): \_\_\_\_\_  Tobacco Use - How many packs per day? \_\_\_\_\_  
 Alcohol Use – How much per day? \_\_\_\_\_  
 Sun Exposure:    Work Outdoors    Outdoor Recreation    Tanning Beds

**Skin Cancer and Sun Exposure History**

Sun Exposure:    Work Outdoors    Outdoor Recreation    Tanning Beds  
 Basal Cell Carcinoma \_\_\_\_\_ Site \_\_\_\_\_ Date \_\_\_\_\_  Multiple BCC \_\_\_\_\_  
 Squamous Cell Carcinoma \_\_\_\_\_ Site \_\_\_\_\_ Date \_\_\_\_\_  Multiple SCC \_\_\_\_\_  
 Melanoma: \_\_\_\_\_

**Medical History: (Check appropriate box)**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Lupus
<input type="checkbox"/> Asthma	<input type="checkbox"/> Herpes (Fever Blisters)	<input type="checkbox"/> Neurological Disease
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Hives	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Coronary Artery Disease (Heart Disease)	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Seizure
<input type="checkbox"/> Eczema	<input type="checkbox"/> Keloids (Thick Scars)	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Hay Fever (Allergies)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancers-Other than Skin: Type: _____ Date: _____

**Surgical History: (Check appropriate box)**

Appendectomy (Appendix)    Coronary Bypass Surgery    Gallbladder  
 Hip Replacement – Right or Left    Knee Replacement – Right or Left    Mastectomy (breast removed)  
 PE Tubes (tubes in ears)    Tonsillectomy (tonsils)  
 Other \_\_\_\_\_

**Immunizations: (Shots) and Last Date Received:**

Flu \_\_\_\_\_    Pneumonia \_\_\_\_\_    Tetanus \_\_\_\_\_  
 Required Childhood Shots (If applicable) \_\_\_\_\_

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 Signature

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 Date